## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  (XI) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER  395883  NAME OF PROVIDER OR SUPPLIER: PENNWOOD NURSING AND REHABILITATION		STREET ADDRESS, 909 WEST ST			(X3) DATE SURVEY COMPLETED: 03/29/2023		
CENTER LLC  STATE LICENSE NUMBER: 016002			PITTSBURGE	I, PA 15221			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0000	Based on a Focused Infection Control Survey and an Abbreviated Survey in response to one complaint completed on March 29, 2023, it was determined that Pennwood Nursing and Rehabilitation Center was in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.		F 0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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## **Certified End Page**

## PENNWOOD NURSING AND REHABILITATION CENTER LLC

STATE LICENSE NUMBER: 016002 SURVEY EXIT DATE: 03/29/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debia L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

## **PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY